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Cover Story

A Management Lesson in Existence With Elephants: What Health Care Reform Legislation Means for Behavioral Health Organizations

 It is a strange and tortuous path that has brought the behavioral health field to this point. Over the past 24 months, we have seen major changes in the economy, in policy, and in legislation completely reshape the financing of the health and human services – and the behavioral health and social service niche within it. (This is happening at the same that science is reshaping our understanding of the brain, brain disorders, and behavior.)

Many people often doubt changes in policy and regulation gelling with this simultaneous consumer and tech revolution. All skepticism aside, this 'era of bioconnectivity' is creating a synergistic environment that spans science, finance, government, and technology. Bioconnectivity is, essentially, the merger of data from EMR, claims databases, and clinical data from medical devices with connectivity technology linked to provider organizations, payers, and consumers alike.

As is the case in much of history (and certainly of U.S. policy), the current market environment is the creation of synchronicity – six concurrent major developments in the U.S. economic and political life:

- Banking crisis
- Recession
- The bank bailout (TARP)
- Parity legislation
- Stimulus Package (ARRA)
- Health care reform legislation

The banking crisis brought with it political tumult, a sudden collapse of the credit markets, unemployment, great fear in the American public, and a lingering recession. The Bush Administration's answer to the banking crisis was the Troubled Asset Relief Program, TARP, a $250 billion piece of legislation to preserve existing banking institutions. But, as all things political can't proceed without tinkering, the long-lingering behavioral health parity bill was

attached to the TARP legislation – and thus became the law of the land. The parity bill is the silver lining in the cloud of bank collapse. In the months that followed the bank collapse and TARP, we got a new president and a recession.

Then came the Obama Administration's answer to the recession – American Recovery and Reinvestment Act, ARRA – affectionately known as the Stimulus package. ARRA was half tax relief, a quarter State Medicaid relief, and another quarter 'other worthy initiatives.' And, it was within the shadow of the Stimulus bill that the Obama Administration passed the health care reform legislation using the age-old reconciliation process.

Synchronicity or not, it brings to mind the African proverb, "When elephants fight, it is the grass that suffers." I think the consumers did well with parity and health care reform. But in this metaphor, it is the provider organizations that are the proverbial grass on the political playing field of elephants.

Strategic Implications Of These Legislative Initiatives

Sorting through the many-faceted changes facing the health care field over the next three years, it is a challenge to come up with the specific factors that we need to guide organizational development. My colleagues and I have completed extensive analysis and modeling of the legislation and have identified what we think are **four key strategic implications for behavioral health provider organizations over the next 36 months:**

- **Most behavioral health dollars will flow through health plans**
- **Changes in finance and technology will increase preparation of behavioral health services provided via 'primary care**
- **Health plan-based financing will draw clear lines between 'health' services and 'social' services**
- **Comparative effectiveness initiatives will increase the private pay market in behavioral health**

Most Funding Will Flow Through Health Plans

With a combination of parity and greatly reduced uninsured population, most behavioral health treatment will be funded by health plans (private, Medicaid, Medicare, etc.). Federal grants and state program dollars that make up traditional 'safety net' funding for behavioral health will diminish – both because of lack of decreased consumer need and increased demand for funding for new 'entitlements.' The management implications of this shift are many. .Listed are a few key considerations:

- Successful provider organizations need an 'expert' process in working with third-party payers
- Financing of delayed cash flow will be a growing issue
- One key focus of marketing efforts will be optimization of FFS reimbursement in health plans

Financing and Technology Will Increase Behavioral Health Services Provided Via 'Primary Care'

Parity provides equal coverage of behavioral health services, and the health care reform legislation encourages integration of primary care with all specialty care. The synchronistic combination of these factors – along with new service delivery technologies and new clinical interventions based on brain science – will encourage an increase in the preparation of behavioral health services delivered in primary care settings. These services will not be the services for consumers with disabilities and complex conditions. Rather, "standard" behavioral health services for the other 80% of the population.

Primary care settings shouldn't be confused with primary care physicians (PCPs). While PCPs will certainly be providing more behavioral health services in their office settings, the largest expansion of behavioral health services will be in retail clinics delivered on-line in consumers' homes, and inserted in health clinics via e-health technologies.

What will remain for behavioral health services outside of primary care settings? The answer is clinical services for consumers with chronic and complex behavioral health conditions. And, it is likely that the services for these consumers will be channeled to highly specialized organizations with the ability to provide a wide array of services to this specific population using some type of risk-based financing. For executives of behavioral health provider organizations, this is a call for new strategy – deciding whether integrated service models or disease management models are the direction for their organization.

Health-Insurance Based Financing Will Draw Clear Lines Between 'Health' and 'Social' Services

One clear effect of increased financing of health benefits through health plans (and the very likely increase in the use of managed care financing models) is that there will be a clear definition of what constitutes 'health care' services. We'll see more medical necessity criteria used for standard behavioral health care for the majority of consumers.

Services that are considered "social supports" (services not meeting medical necessity criteria) will be available only for consumer with chronic and complex behavioral health conditions—and likely only under risk-based financing. For most behavioral health provider organizations, this likely future situation demands a scenario-based analysis of your current consumer base and service array. How many of them will meet the chronic/complex case definition? What preparation of services delivered by your organization will clearly meet the 'medical necessity' test? Of the services, how would their utilization change in a capitated finance environment. What will risk-based financing models (case rate, episodic payments, etc.) for these services look like?

Comparative Effectiveness Initiatives Will Increase The Behavioral Health Private Pay Market

The last of the implications of health care reform for our field is the likelihood that the use of comparative effectiveness analysis will increase the promotion of behavioral health funding from private pay. Comparative effectiveness analysis, which is essentially a disease-state-specific meta-analysis of evidence-based practices – "recommends" clinical protocols based on outcome

and cost. There are two groups of services that will likely be in the private pay domain. The first group includes more expensive treatment approaches that do not have good cost-offset data and are likely to not be "recommended" competitive effectiveness analysis. The second group is new treatment technologies that are not included in the competitive effectiveness evaluation process. As a result, the private pay market will change dramatically – it will likely include many 'traditional' therapies preferred by consumers and emerging technologies. To address this increase in private pay, many provider organizations will need enhanced intake billing, and market functions.

The magnitude of the market impact of these four factors is unknown right now. While we have the legislation, the regulations are being crafted at this very moment. And, in the case of health care reform (and parity), the devil is, literally, in the details. Measuring how beneficial this legislation is for the consumers we serve – and the implications for behavioral health professions and provider organizations – will be a function of these regulations.

Right now, policymakers are sorting through the meaning of parity – the issue of combined consumer out-of-pocket limits, of quantitative benefit equality, and of equity in non-quantitative benefit management. (See the live links featured below and continue on the back page of this issue) The battle with health insurers over transparency and minimum requirements for medical loss ratios are pending. It is critical to both advocate for consumer-centric regulations and, when the regulatory dust settles, understand the implications and opportunities – to get your organization's management team on board for the changes in the road ahead.

Just one word of advice for your management team during this time of 'gigantic change' – "When eating an elephant, take one bite at a time."

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